

THE ELEPHANT IN THE ROOM:
POVERTY AND MENTAL HEALTH AMONG REFUGEE WOMEN

by

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Abstract

Background: Refugees arriving in the United States experience mental illness at a higher rate than the general public (Fazel, Wheeler, & Danesh, 2005). Female refugees in particular experience poorer mental health outcomes than their male counterparts (Porter & Haslam, 2005). Poverty contributes to mental illness (Kuruville & Jacob, 2007), and most refugees experience poverty at multiple (if not all) points in their displacement and resettlement journey.

Methods: From 2013 to 2016, brief structured interviews were conducted with 53 female refugees from the Democratic Republic of Congo, Burma, Iraq, and six other countries who had been resettled in central North Carolina within the preceding five years. The interviews were one component of a larger study to assess the prevalence of emotional distress symptoms in newly arrived refugees, and to evaluate the mental health treatment provided. The purpose of the current study was to explore female-identified refugees' perceptions of what influences their mental health, with particular attention to the role of poverty.

Results: There is broad support within this group of female refugees for the use of mental health screening questions. Both individual and group treatment are viewed positively by most respondents who engaged in treatment. Practical concerns, such as finding a job, paying rent, and learning English were the most widely cited contributors to poor emotional wellbeing.

Conclusions: While the refugee women in this sample recognized the value of mental health screening and treatment, many barriers impeded their achieving a sense of emotional wellbeing. When considering interventions to improve mental health among

refugee populations, it is necessary to take a holistic approach to building family resilience in the face of poverty, addressing practical as well as emotional needs. More research is needed on the role of mental health in acculturation and integration, particularly in women.

Background

According to the 1951 Refugee Convention, a refugee is someone who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country” (United Nations High Commissioner for Refugees, 2016). The circumstances that precipitate a person fleeing their country, conditions of the refugee camps they may end up in, and the challenges of resettlement are often fraught with traumatic experiences that can have far-reaching impacts on mental health (Porter & Haslam, 2005). Refugees resettled in Western, high-income countries experience mental illness, particularly post-traumatic stress disorder, at up to ten times the rate of the populations they are entering (Fazel et al., 2005). While the prevalence of trauma and mental illness among refugees in the US is well-documented, there is no formal process for screening newly arrived refugees for emotional distress (Shannon et al., 2012). The lack of identification and treatment of mental health disorders puts refugees at a disadvantage in an already stressful process of resettlement.

Women refugees in particular experience poorer mental health outcomes than their male counterparts (Porter & Haslam, 2005). Additionally, since caregiver mental illness is associated with increased symptoms of traumatic stress in children, among both

refugees and non-refugees, maternal emotional distress can be thought of as both a predictor and proxy of child mental health (Panter-Brick, Grimon, & Eggerman, 2014).

While it has long been acknowledged that the prevalence of mental health problems among refugees is high, and that there is significant and additional stress associated with acculturation (Williams & Berry, 1991), little attention has been paid to the role of poverty in the refugee resettlement experience. Around the world, poverty is associated with mental illness and mental illness appears to perpetuate poverty; this association is stronger among women, particularly in single mothers and in cultures where there are stark gender power imbalances (Anakwenze & Zuberi, 2013; Kuruvilla & Jacob, 2007). Even if refugees were not living in poverty in their home country prior to displacement, the vast majority experience the deprivation of poverty in refugee camps or other transitional living situations, and then are resettled into poverty in the United States (Porter & Haslam, 2005). Poverty compounds the stress of acculturation and exacerbates trauma symptoms. For refugees resettled in the US, particularly female refugees, more research is needed to tease out how poverty contributes to mental health problems, and how to mitigate the impact through targeted interventions and policy change.

Study Objective

The purpose of this study is to explore female-identified refugees' perceptions of what influences their mental health. In particular, the objectives are to describe events and conditions related to an increase or decrease in emotional distress; to differentiate the role of poverty from the role of acculturation in mental health; and finally, to identify factors related to "help" or treatment that can be used to improve mental health services for this population.

This is part of a larger study to estimate the prevalence of emotional distress in recently arrived refugees in central North Carolina, and to evaluate the acceptability, accessibility, and efficacy of different treatment modalities. Since this is such a unique population with diverse needs, qualitative methods are appropriate to better understand the patterns of improvement or degeneration in mental health and what aspects of treatment should be conserved or changed. The literature documenting the resettlement experiences of female refugees in the US is scant; thus, taking a qualitative approach is a prudent first step in guiding future qualitative as well as quantitative research with this population.

Theoretical Grounding and Conceptual Framework

The theoretical approach taken in this study was a combination of phenomenology and feminist inquiry. It identifies the time of resettlement in the United States as a distinct period, and aims to come to a deeper understanding of the phenomena surrounding poverty and mental health in that period. This study also prioritizes the voices of women, especially recognizing that women are disproportionately impacted by both mental illness and poverty. Additionally, in the feminist tradition, each story is taken as the truth of the person telling it, recognizing that there is no universal experience for women resettled as refugees in the United States.

The conceptual framework developed for this study (Figure 1) is similar to the Core Stressors of Refugees model (Figure 2) from the National Child Traumatic Stress

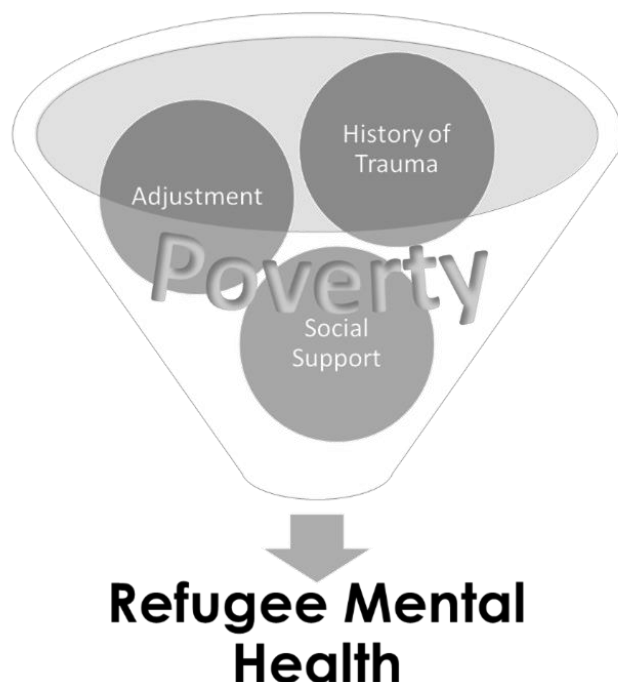


Figure 1. Conceptual model of factors that influence refugee mental health.

Network (The National Child Traumatic Stress Network, 2010), but emphasizes the impact of poverty as a mediating factor for the three other major contributors: history of trauma, adjustment, and social support. Much literature acknowledges financial factors as a source of stress for refugees (Franks, Gawn, & Bowden, 2007;

Rasmussen, Grager, Baser, Chu, & Gany, 2012; Williams & Berry, 1991), but, like the NCTSN model, often includes financial stressors within the category of resettlement, implying that they are unique to this period. This study examines poverty as a factor permeating all aspects of refugee life. Poverty exacerbates the impact of histories of trauma by increasing pervasive stress; it impedes language development, educational attainment, and healthcare access as the cost of transportation, childcare, tuition, insurance and other enabling services is beyond reach; and it increases social isolation by inhibiting the mobility necessary to establish and maintain strong social networks in decentralized cities.

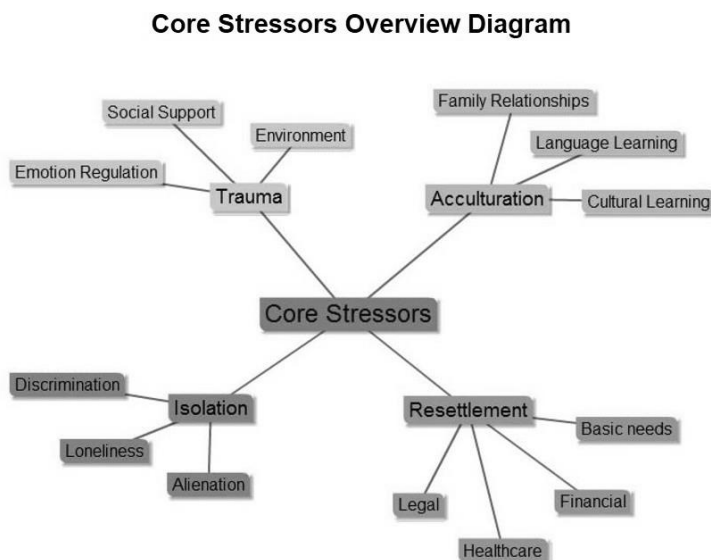


Figure 2. The core stressors of refugees. The National Child Traumatic Stress Network. (2010). Refugee Services Toolkit: Core stressors overview. Retrieved from <http://learn.nctsn.org/mod/book/view.php?id=4518&chapterid=36>

Methodology

Sample

The data used for this analysis were collected by Refugee Mental Health and Wellness Initiative (“Refugee Wellness”) staff between 2013 and the end of 2015. Structured individual interviews were conducted with participants at the end of the larger study period, which included an initial mental health screening, optional treatment, and a second screening. The participants’ responses were interpreted into English by trained interpreters and transcribed by agency staff. The total larger study sample of refugees who had completed at least one screening was 260 as of March, 2016. Participants were recruited using purposive criteria sampling from local refugee resettlement agencies. To be included in the larger study, the participant must be a refugee adult resettled in Wake, Durham, or Orange counties in North Carolina within the past five years. From that sample, female-identified participants were selected who had completed the end-of-engagement qualitative interview, resulting in a sub-sample of 53 for the current study.

Females make up 43% of the larger study sample, and nearly half of women completed the end-of-engagement qualitative interview that was analyzed in the current study.

Broken down by nationality and gender, the top four nationalities were the same in both the study sample and women in the larger sample: Democratic Republic of Congo, Burma, Iraq, and Somalia (see Table 1).

Table 1.

Nationalities of participants in study compared to women in larger study sample.

Nationality	Study Sample		Larger Study Sample	
	Number	Percent	Number	Percent
DRC	24	44.4%	41	36.6%
Burma	9	16.7%	13	11.6%
Iraq	8	14.8%	17	15.2%
Somalia	3	5.6%	10	8.9%
Other	9	16.7%	31	27.7%

Quality of the data

The data were collected by social workers and Master of Social Work students familiar with the study. Since most of the interviews were conducted with an interpreter, it is not guaranteed that the participants' precise wording or meaning were relayed accurately. Codes and corresponding quotes were checked by the principle investigator of the larger study and one of the research assistants familiar with both the data and qualitative research in order to improve the quality of the analysis.

Concept terms

Since one of the key aims of this study was to explore the role of poverty in mental health among refugee women, poverty as a concept had to be separated from other

practical stressors of adjustment in the resettlement period. Practical stressors were defined as external challenges of everyday life for resettled refugees, such as employment, learning English, and navigating systems in the US. These were then delineated into two sub-groups: practical stressors associated with resettlement and those associated with poverty. The decision of whether to categorize a practical stressor into one group or the other depended on whether this was something that was unique to the refugee experience, or was experienced widely among people living in poverty in the US. For example, learning English was categorized as a resettlement stressor, whereas paying rent was categorized as a poverty stressor.

Data Analysis

Data transcripts were analyzed using open and axial coding in Atlas.ti statistical software, version 7.5.10. Five major themes came out of the data, and were subsequently used as super codes for the analysis: hope, practical stressors, mental health, treatment, and social support. Within those themes, 38 subcodes provided a more detailed look at the factors within each category. Figure 3 shows the network view of codes, subcodes and their relationships.

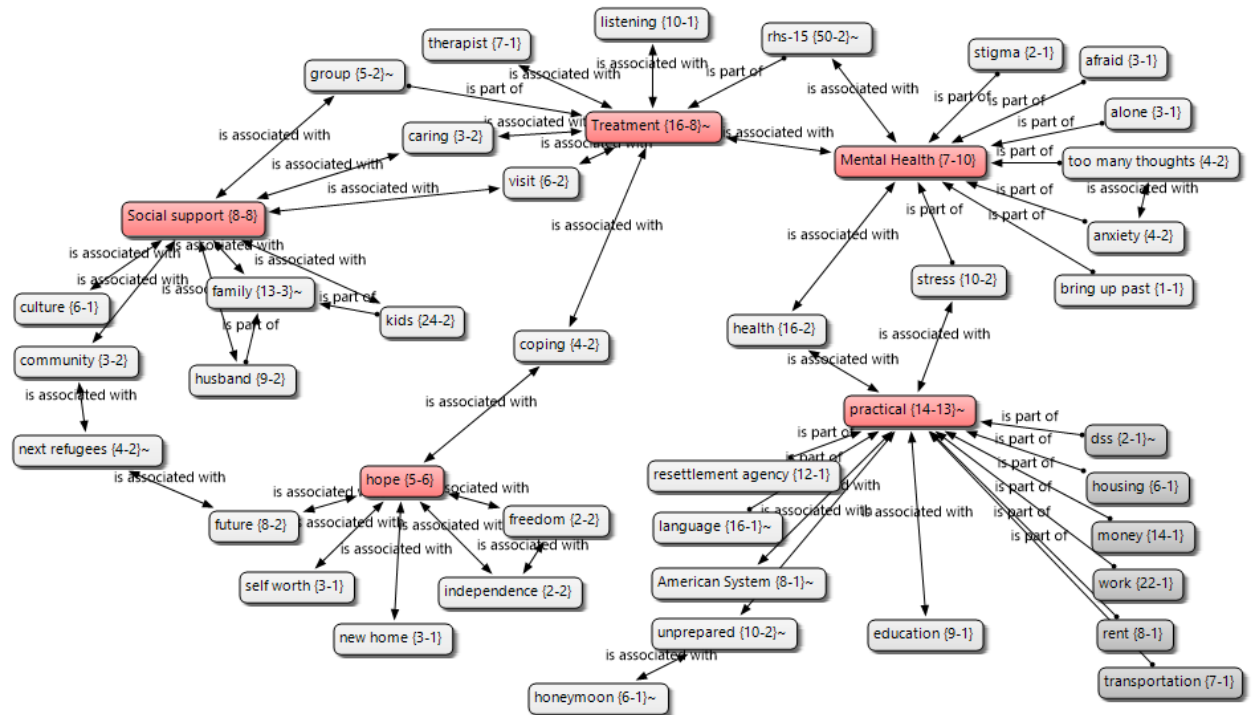


Figure 3. Network view of super codes and subcodes used in data analysis

Results

Treatment

Based on feedback from study participants, there is broad support for the use of mental health screening questions. Participants discussed the value of the mental health screening questionnaire to contribute to general knowledge of the emotional wellbeing of refugees and to improve services available to future refugees. Multiple participants also related that the act of responding to the questionnaire improved self-awareness, and that it was personally beneficial for them to reflect on their emotional state. The vast majority stated it was best to do the screening in the home.

Participants who engaged in treatment provided by Refugee Wellness expressed overwhelmingly positive views of both individual and group treatment. Key themes of

what was felt to be helpful about treatment were having someone listen to them, someone who showed caring and concern, and learning coping and relaxation strategies. In addition, assistance navigating US systems and advocating on the refugees' behalf to the resettlement agencies appeared commonly in what was named as being helpful about treatment. A number of participants stated that visits in the home were especially beneficial because of transportation and childcare concerns.

"She [the Refugee Wellness counselor] supports you and shows you the ways to cope with situations... Even with words, it helped a lot." (P.3, Iraq)

"Today you talked to [resettlement caseworker] for me, and that takes me a really long time. You applied to another agency for me after I told you my problems and they will come see me next week." (P.116, DRC)

Practical Concerns

Practical concerns were the most widely cited contributors to emotional wellbeing. Concerns related to resettlement, that is concerns unique to the refugee experience, included navigating US systems and culture, interactions with the refugee resettlement agencies, and learning English. When participants brought up resettlement agencies, it was almost always to relate stories of disappointment, frustration, and misunderstanding.

"We have responsibilities, and the [resettlement] organization left us and said 'we did our job'. I still don't have language or any resources." (P.31, Iraq)

"It would be good if the agency could help us for 6-8 months, until we learned the language. We have no one to turn to now, if something goes wrong. I don't want refugees who come after us to be in the same situation." (P.58, DRC)

Related to this disappointment and frustration with resettlement agencies, many participants described being generally unprepared for what life in the US would be like. Multiple participants described something like a honeymoon period, when they were being supported by the resettlement agency and thought everything in the US was wonderful. The transition out of that honeymoon period when the financial and logistical support is withdrawn is described as a major source of stress and disillusionment.

“When they come in the beginning they will think they’re in paradise.”

(P.147, Iraq)

“At the beginning they pay everything. When the agency abandons is when you should come ask [mental health screening] questions.” (P.164, DRC)

The other side of practical stressors were those common to the experience of poverty in the United States. Making ends meet with low-wage jobs, the unpredictability of employment hours and scheduling, managing medical conditions without health insurance, struggles with transportation, and living in substandard housing came up repeatedly in the interviews. Work was by far the most cited influence on mental health.

“Working at Target makes me feeling nothing, worthless.” (P.147, Iraq)

“When we work that doesn’t cover all our expenses. Even now, before we start paying everything we know our funds won’t cover everything.” (P.241, DRC)

“I have lots of health problems and vomit a lot of the time. My Medicaid ended and so did my medication. I’m worried about my daughter’s diagnosis and if she falls sick, I don’t know what we’re going to do. Where will I get money?” (P.116,

DRC)

Social Support

Families were the primary source of social support discussed by participants. Anxiety about family members left behind in camps or countries of origin was a common theme. The family members that people did have around them were generally discussed as being a major source of strength, but at times an additional stressor. Multiple mothers expressed feeling distress when their children were away in school. Isolation came up in different forms many times. Sometimes the only perceived social support a participant expressed was from the Refugee Wellness staff or other helping professionals.

“When I’m home alone and the kids are in school, I’m sad. I’m from a big family and used to going to see the neighbors, but I’m scared of my neighbors here, it’s different. There was a lot of community around me in Somalia.” (P.123, Somalia)

“Before I was so scared and I didn’t know how to cope but when people came and encouraged me that helped me feel better and that’s why I feel better now.”

(P.184, Burma)

“I have a home care nurse and we talk to each other and I feel not lonely. I have someone to talk to and they come to visit. Sometimes I don’t understand completely, but I laugh at them.” (P.181, Burma)

Hope

Expressions of hope occurred frequently in the interviews. Most often, these were related to having overcome challenges, or having a better understanding of their new surroundings. Hope was closely tied to social support. Participants described having more people around them as being the antidote for feelings of hopelessness and fear. The treatment provided by Refugee Wellness was also given as a factor that enabled feelings of hope.

“What you said was true. You gave us hope that things would get better, and here we are.” (P.3, Iraq)

“In these moments when we’re all together and talking it’s a time we can remove ourselves from all these difficulties and just be with people.” (P.253, Iran)

Discussion

The refugee women in this sample recognized the value of mental health screening and treatment, although many barriers impeded their achieving a sense of emotional wellbeing. It is possible that their experiences of mental illness exacerbate their poverty, by making it harder to secure and hold down jobs, or that the constant stress of living in poverty negatively affects their mental health, or that poverty just makes mental health treatment that much harder. It is likely that, as Anakwenze and Zuberi (2013) point out, the relationship between poverty and mental illness is complex and bidirectional. Whatever the pathway, it is necessary to acknowledge that the reception and placement process in the United States situates resettled refugees on the bottom rung of the economic ladder, putting them up against the same struggles that others living in poverty face. Not only are they resettled into poverty, but they then have the additional challenges of adapting to a new language, culture, and systems.

When considering interventions to improve mental health among refugee populations, it is necessary to take a holistic approach to building family resilience in the face of poverty, addressing practical as well as emotional needs. One way to do this is to incorporate therapeutic elements into practical skill-building. For example, job-skill-development workshops could be structured in a series in single-gender, single-language groups. In addition to enhancing skills for potential employment, the workshops could

create a safe space for sharing emotional struggles and offering support, as well as teaching coping skills for dealing with stress. Resettlement agencies around the country already offer employment assistance and other forms of practical skill-building in a variety of ways. With additional training for resettlement staff, or by hiring or contracting with mental health professionals to co-facilitate groups and workshops, resettlement agencies could support the emotional wellbeing of their clients without having to invest in individual therapy.

For refugees who are in need of or seek individual therapy, traditional talk-therapy could be enhanced by taking an empowerment approach, emphasizing self-efficacy and self-advocacy. Therapeutic goals could be matched with practical goals at the beginning of treatment and revisited each session. For example, the objectives of decreasing panic attacks and finding safe, stable housing could be pursued in parallel in the treatment of anxiety. Both of the above approaches in group and individual settings acknowledge that practical and emotional components are equally important sides of overall wellness.

The principle limitation of this study is the depth of the interviews. Although the participants were very forthcoming with information, this was a structured interview with no room for probing or delving deeper into women's experiences. In addition, responses were transcribed in the moment by Refugee Wellness staff, rather than being recorded and transcribed at a later time. While this is important for the expediency of the data collection, the rigor of the analysis could have been improved by having a recording to reference. This would have also allowed for other interpreters or native-speakers to spot-

check the interpretation, to make sure that participants' responses were being relayed accurately.

While interpretation creates a possible barrier in understanding, it also enables a fuller expression by participants by allowing them to speak in their native languages. This also allows for more diversity of responses, since participants were not excluded for a lack of English proficiency. In spite of the constraints of language and interview structure, a wealth of information was still collected. It is clear in many of the responses that rapport and trust have been developed with the Refugee Wellness staff member conducting the interview.

For future studies, the success of this data collection method could be leveraged to gather more, and more meaningful, testimony. The questions in the structured interview guide could include possible follow-up questions to assist interviewers in drawing out important aspects of the participants' stories. Asking for concrete examples of when the participant encountered a situation that was overwhelming, or a situation where they overcame an obstacle could be a start, with possible follow-up questions to probe into the feelings around these events and support they accessed. Questions about what "treatment" means to the participants, as well as what they imagine a path to healing or recovery could look like would be useful in understanding what people are looking for in mental health services.

Although the refugee women in this study face additional barriers than the average American living in poverty, they also have significant stores of strength and resilience. It is a testament to that resilience that many refugees are able to adjust to life

in the United States, weave a new social fabric, and achieve some sense of stability and success in their new home.

“I like it here; I want to stay here. This is my home now.” (P.3, Iraq)

Acknowledgements

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